TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MICHAEL LOPEZ, DC

Respondent Name
PRAETORIAN INSURANCE CO

MFDR Tracking Number
M4-15-3899-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider, Dr. Lopez has included dictations for each date of service. Dr. Lopez has outlined key components regarding the patient's office visits. All of this documentation was sent in for reconsideration several times. Work status 73 was paid, which is condescending since the rule states cannot have work status form without an office visit."

Amount in Dispute: $405.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2014	CPT Code 99214-25 Office Visit	$165.84	$0.00
April 7, 2014	CPT Code 99213 Office Visit	$112.33	$0.00
April 7, 2014	CPT Code 99080-73 Work Status Report	$15.00	$0.00
December 29, 2014	CPT Code 99213 Office Visit	$112.33	$0.00
TOTAL		$405.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 29-The time limit for filing has expired.
   - 15, 150-Payer deems the information submitted does not support this level of service.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issue

1. Did the requestor waive the right to medical fee dispute resolution for dates of service March 6, 2014 and April 7, 2014?
2. Does a timely billing issue exist?
3. Does the documentation support level of service billed on December 29, 2014?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are March 26, 2014, April 7, 2014 and December 29, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on August 3, 2015. This date is later than one year for dates of service March 26, 2014 and April 7, 2014. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service March 26, 2014 and April 7, 2014.
2. According to the explanation of benefits, the respondent denied reimbursement for date of service April 7, 2014 based upon reason code "29." As stated above, this date of service was not submitted timely to the Division in accordance with 28 Texas Administrative Code §133.307(c)(1); therefore, this issue will not be addressed in this decision.
3. The respondent denied reimbursement for the office visit rendered on December 29, 2014 based upon reason codes "15" and "150."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99213 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   A review of the submitted medical report does not support 2 of the 3 key components for billing CPT code 99213; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/03/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.